North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
and Substance Abuse Services

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Richard J. Visingardi, Ph.D., Director

June 25, 2003

MEMORANDUM

TO: Area Directors

FROM: Stanley A. Slawinski, Ph.D., Chief
State Operated Services

SUBJECT: ADATC Bed Allocations for SFY 2003-2004

The purpose of this communication is to advise you of the bedday allocations for the three state operated Alcohol and Drug Abuse Treatment Centers (ADATCs) and confirm that these separate allocations also begin with the July 1, 2003 implementation of the psychiatric hospital bedday allocations. This memorandum also provides clarification on the process of authorizing admissions to ADATCs which varies slightly from the authorization of admissions to the psychiatric hospitals.

As you are aware, the Division developed a revised bedday allocation plan and system to complement the efforts underway to expand community services and downsize state psychiatric hospital bed capacity. Staff from your respective programs were invited to attend training sessions that were provided regionally June 3rd-5th, 2003. *During the presentation of the authorization procedures your staff were informed that the same authorization and reauthorization forms [DMH 1-73-00 (Rev 0/03) and DMH 5-99-00 (Rev 6/03)] would be used to authorize admissions and continued stay for the ADATCs.* Copies of both forms are attached for your reference.

Since the admissions for the ADATC are scheduled in advance it will be necessary for the area program to initiate the authorization form and complete the following items:

1. Fill in Part 1 of the form as well as Part 2.
2. Record the authorization number in the appropriate box.
3. Record the number of days authorized (in the box labeled "From:___) rather than the dates, as a bed may become available prior to the scheduled admission date.
4. Faxed or mail the completed authorization form to the ADATC after confirmation of the scheduled appointment and no later than the actual arrival of the admission.

MAILING ADDRESS:
3006 Mail Service Center
Raleigh, NC 27699-3006

Telephone 919-733-3654
FAX Number 919-508-0955

LOCATION:
Albemarle Building
325 North Salisbury St.
Raleigh, NC
State Courier: 56-20-24

The ADATCs will be responsible for completing the "Reauthorization for Continued Stay" DMH 5-99-00 (Rev 6/03)] and faxing it to the area programs for additional days, as is the procedure for the psychiatric hospitals.

With the exception of the above variation in authorization procedures the same rules, appeal procedures, and provision of monthly reports apply to the ADATC bedday allocation process.

A chart of the bedday allocations are attached for your review. These initial allocations are based on ADATC utilization by area programs during FY 2000 through 2002. It is the intent of the Division, as is the case with the psychiatric hospitals, to move toward a population based allocation over several years. One possible variation that may influence ADATC bedday allocations in the future is the addition of the acute crisis/detox beds to be established at each facility. Since the acute units will open on different schedules during the next fiscal year due to variations in construction schedules, the attached ADATC bedday allocations will apply to both acute and rehabilitation admissions throughout the SFY 2003-2004 except for two special populations. As you are aware the perinatal and deaf/hard of hearing programs at the Walter B. Jones ADATC accept statewide referrals and as such are not in the bedday allocations. A schedule of adjusted bedday allocations projected through 2007 will be forwarded under separate cover during the next fiscal year.

We hope that this helps to clarify your questions concerning implementing the new process for the ADATCs. If you or your staffs have additional questions regarding the bedday allocations or the authorization or reauthorization process for the ADATCs you may contact Doug Baker or Don Herring in the State Operated Services office at 919-733-3654. You may also contact your respective regional ADATCs for further questions.

SAS/DB

attachments

cc: Secretary Carmen Hooker Odom
Lanier Cansler
Jim Bernstein
DMH/DD/SAS Executive Leadership Team
Carol Duncan-Clayton
Robin Huffman
Fred Waddle
Patrice Roesler
ADATC Directors
Area Substance Abuse Coordinators

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Bedday Allocations for 2003-2004 for NC Alcohol & Drug Abuse Treatment Centers

ADATC Facility	Area Program/Local Management Entity	Bedday Allocations Based on 2000-2002
Walter B. Jones	Southeastern Regional	1,169
	Cumberland	254
	Southeastern Center	4,956
	Onslow	1,961
	Wayne	655
	Wilson-Greene	756
	Edgecombe-Nash	919
	Riverstone	462
	Neuse	830
	Pitt	1,875
	Roanaoke-Chowan	432
	Tideland	867
	Albemarle	1,732
	Duplin-Sampson-Lenoir	1,184
	Total	**18,046**
J.F. Keith	Smoky Mountain	1,764
	Blue Ridge	3,480
	New River	1,083
	Trend	1,677
	Foothills	2,121
	Rutherford-Polk	599
	Pathways	1,285
	Catawba	1,033
	Mecklenburg	5,261
	Piedmont	4,158
	Crossroads	830
	Davidson	1,471
	Total	**24,762**
Butner	CenterPoint	797
	Rockingham	2,057
	Guilford	2,574
	Alamance-Caswell	1,725
	Orange-Person-Chatham	2,901
	Durham	2,618
	Vance-Granville-Franklin-Warren	1,706
	Sandhills Center	2,095
	Lee-Harnett	1,377
	Johnston	552
	Wake	729
	Randolph	818
	Total	**19,949**

STATE HOSPITAL BED DAY ALLOCATION PLAN

1. Basis for Allocation

   Each LME/Area Authority's initial bed day allocation is based on its utilization of the subject beds during fiscal years 2000 through 2002. During the five-year period of 2003 through 2007, the number of bed days available for allocation will be reduced as the number of beds in the hospitals is reduced. Reductions in the number of hospital beds will be facilitated by the expansion of community capacity and the subsequent transfer of funds from the hospitals to the LME/Area Authorities. As the funds are transferred and the hospitals are downsized, the bed day allocation will move from a historical basis to a per capita population basis. At the end of FY 2007, the number of bed days available to each LME/Area Authority will be in direct proportion to the population of the LME/Area Authority.

2. Allocation Categories

   Bed days are allocated per LME/Area Authority in four (4) bed categories:
   - Adult admissions
   - Adult long-term
   - Geriatric admissions
   - Adolescent admissions

3. Authorization

   The LME/Area Authority is responsible for authorizing all admissions and continued stays of patients in the identified bed categories. To provide guidance in initial authorizations, following are the minimum number of days that must be authorized for new admissions:
   - Adult and geriatric admissions: three (3) days
   - Adolescent admissions: six (6) days
   - Adult long-term admissions: 30 days

4. Excess Utilization

   Each hospital has a per diem rate that will serve as the basis for computing cost to the LME/Area Authority if the LME/Area Authority exceeds its bed day allocation. Settlement or reconciliation of bed day utilization will be done at the end of the fiscal year. Each LME/Area Authority is responsible for managing its own bed day allocation. The plan does not allow for the exchange of bed days among LME/Area Authorities.

5. Transportation System

   Each State hospital will operate a patient transportation system to facilitate timely discharge of patients. The systems will be funded by savings from downsizing and will be used only as a last resort for transporting discharged patients to their home communities when county transportation is untimely or unavailable.

Other Items

- Differences of opinion between an LME/Area Authority and hospital regarding authorization or bed day utilization will be governed by the provisions of 10 NCAC 15A .0126.
- Patient's county of residence is as defined in NCGS 122C-3 (10).

Revised/May 14, 2003

NORTH CAROLINA DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/ SUBSTANCE ABUSE SERVICES

☐ **Section I:** Fax to: _____ Area Program
Contact Person: _____
Fax Number: _____ Date: _____
From: Dorothea Dix Hospital/Ward/Bldg: _____
Person Faxing: _____ Phone#: _____
☐ **Section II: Fax to:** _____
Fax#:

REAUTHORIZATION FOR CONTINUED STAY

SECTION I: **(To be Completed by Hospital Staff on Request for Reauthorization)**

Patient Name: _____ Medical Record #: _____ Date of Birth: _____

Type of Beds: ☐ Adult Admissions ☐ Adult Long-term ☐ Geriatric Admissions ☐ Adolescents/Child Admissions

***Date Current Authorization Expires:** _____ Authorization #: _____ Admit Date: _____

Social Worker: _____ Phone #: _____ Fax #: _____

(Attending Physician is responsible for completion)
DSM IV Diagnosis: _____

Current Medications: _____

RATIONALE FOR CONTINUED STAY **(Check 1 or 2 and all that apply and complete 3 and 4)**

☐ **1. Patient requires psychiatric hospitalization and cannot be managed with less intensive supervision**
- ☐ dangerous to self
- ☐ dangerous to others
- ☐ dangerous to _____
- ☐ current suicidal ideation
- ☐ current homicidal ideation
- ☐ persistent psychotic symptoms
- ☐ impaired judgment, reality testing, and/or thinking
- ☐ neglect of personal hygiene and health endangering welfare
- ☐ seclusion/restraint within past 24 hours
- ☐ wandering; requires locked facility
- ☐ refusing medication and/or treatment
- ☐ other: _____

☐ **2. Patient cannot be discharged safely**
- ☐ unable to manage medical illness with available dispositions
- ☐ no available transportation
- ☐ no disposition has been found to meet patient needs
- ☐ other: _____

☐ **3. Authorization dates requested**
(the form date must be the next day after the *above expiration date)
***From** _____ **To** _____
(mm dd yy) **(mm dd yy)**

☐ **4. Clinical Status: (MUST COMPLETE LEGIBLY)**

Clinical Status: Continued _____

_____/_____ _____ _____
Attending Physician's Signature Printed Name Date Phone Number

SECTION II: **(To be Completed by Area Program Authorizing Staff)**

Date Requested Received: _____ Date Requested Approved: _____ Authorized From: _____ To: _____
(mm dd yy) (mm dd yy)

Date Requested Denied: _____ **Must Complete Form DMH 5-99-97 (B) to Accompany this form is Denying.**

Staff **Authorizing** ☐ or **Denying** ☐ Continued Stay: (Printed Name): _____

_____ _____ _____ _____
Signature Date Phone Number Fax Number

Fax: As Noted Above
Completed Form: Medical Record

NORTH CAROLINA DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/ SUBSTANCE ABUSE SERVICES

Area Program Medical Record #: _____

Hospital Medical Record #: _____

REGIONAL REFERRAL FORM

1. TO BE COMPLETED BY ADMITTING FACILITY

☐ **Area Program Referral to Regional Psychiatric Hospital**

☐ **Referral to ADATC**

☐ **Authorization for Patient Not Referred by Area Program**

Area Program: _____ Date: _____ Time: _____

Client's Name: _____
Last First Middle/Maiden

Alias Names: _____

Client's Address: _____

Responsible Party's Name and Address: _____

Responsible Party's Telephone Number: Home:(___)_____ Work:(___)_____

Date of Birth: _____ Race: _____ Commitment Type: _____
MM DD YY

BEFORE ADMISSION CALL:

Referring County: _____ **Phone #:**_____	**Responsible County:** _____ **Phone #:**_____
Time of Phone Call: _____	Time of Phone Call: _____
Hospital Staff Making Phone Call:_____	Hospital Staff Making Phone Call:_____
☐ No Response Within 1 Hour of Call:	☐ No Response Within 1 Hour of Call:
If Response – Person Authorizing Days:_____	If Response – Person Authorizing Days:_____
Authorization #:_____ From:_____ To*:_____	Authorization #:_____ From:_____ To*:_____
Hospital Beds ☐ ADATC/SA Bed	Hospital Beds ☐ ADATC/SA Bed
☐ Adult Admissions	☐ Adult Admissions
☐ Adult Long-term	☐ Adult Long-term
☐ Geriatric Admissions	☐ Geriatric Admissions
☐ Adolescents/Child Admissions	☐ Adolescents/Child Admissions
* Day Not Covered	*Day Not Covered

2. TO BE COMPLETED BY AREA PROGRAM

Referral Source to Area Program: _____

Presenting Problem: _____

_____

If currently using: ☐ Alcohol ☐ Drug ☐ Alcohol & Drug Specify: _____

*Psychiatric Diagnosis(es): Axis I: _____

Axis II: _____

*Physical Diagnosis(es): Axis III: _____

*History of Treatment: _____

_____

Previous Admission to Any State Facility (Place and Date): _____

_____

_____

Alternatives Attempted/Considered Prior to Referral to Hospital: _____

_____

Medical History ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Seizure Disorder ☐ Other

Comments: _____

_____

*Current Medications (medical and psychiatric). Include last injection date, side effects, history of compliance, recent labwork, aftercare instructions:

*Client Allergies: _____

Client Adjudicated Incompetent/Minor: Date Adjudicated: _____ If yes, type of guardianship: _____

Pending Legal Charges: ☐ Yes ☐ No ☐ Detainer (County) _____
☐ Unknown ☐ Other _____

House Bill 95: ☐ Yes ☐ No Senate Bill 43 (NGRI): ☐ Yes ☐ No

Area Program Staff to Call for Further Information:

Work Hours: _____ Phone: _____

After Hours: _____ Phone: _____

*Therapist: _____ Phone: _____

*Psychiatrist: _____ Phone: _____

*Case Mgr.: _____ Phone: _____

Third party coverage: Medicaid #: _____ Medicare #: _____ Other: _____

Insurance Co.: _____ Policy Holder: _____ Policy Number: _____

Goal of Hospitalization and Treatment Objectives:

Specific Suggestions for Programming/Treatment Planning:

Release Plans and Placement Considerations:

Relevant Family/Guardian and Social Supports:

Name:	Address	Phone #	Relationship

Form Completed By: _____ _____
Signature/Title Date

*If this information is not available at time of referral, it must be sent to the hospital within one working day of the client's admission.